STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Cardinal Healthcare, LLC
Petitioner **File No. 21-1681**

v

Mid-Century Insurance Company
Respondent

Issued and entered
this 31st day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 28, 2021, Cardinal Healthcare, LLC (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Mid-Century Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on October 13, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue. The Department accepted the request for an appeal on. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on November 9, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on November 23, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home aid services rendered on 14 dates of service[1] under Healthcare Common Procedural Coding System (HCPSCS) Level II codes

[1] The dates of service at issue are August 14 through August 27, 2021.

G0299 and G0156 with a TG modifier. The procedure codes at issue are described as direct skilled nursing services in a home health or hospice setting, each 15 minutes; and home health aide, in a home health or hospice setting, each 15 minutes, and a TG modifier indicates complex/high tech level of care.

With its appeal request, the Petitioner's submitted documentation included an *Explanation of Review* letter issued by the Respondent, its 2019 charge description master (CDM)[2], and a narrative outlining its reason for appeal. The Petitioner stated in its narrative that "the [Respondent]'s payments do not even cover the payroll of the staff." In addition, the Petitioner stated:

> It is my understanding that under the MCL 500.3107, [t]reatment or training rendered after July 1, 2021 and before July 2, 2022 [is reimbursed at] 200% of the amount payable to the person for the treatment or training under Medicare. The billable Medicare codes are the G codes with a TG modifier, which falls under that explanation of payment.

In its denial, the Respondent stated that its reimbursement was the recommended allowance based on "the applicable percentage of the Provider Chare Description Master for subsection 2 and is further adjusted by the annual adjusted [consumer price index]." In its reply, the Respondent stated that the Petitioner's charges were not denied and were processed "in accordance with MCL 500.3157." Specifically, the Respondent stated:

> Codes billed by the provider are not under the Medicare Fee Schedule. As such, reimbursement was issued based on the provider's charge description master.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the

[2] See MCL 500.3157(7).

provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

HCPCS Level II Codes G0299 and G0156 with or without a TG modifier have amounts payable under Medicare when they are billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Codes G0299 and G0156 under on a fee-schedule basis because those codes are not priced separately. Where there is no amount payable under Medicare, reimbursement is calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's submitted CDM as of January 1, 2019 for HCPCS codes G0299 and G0156 with a TG modifier. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure codes at issue for the dates of service at issue is $8.02 per unit for G0299-TG and $4.01 per unit for G0156-TG.

HCPCS code	January 1, 2019 charge description master amount	55% of January 1, 2019 charge description master amount	4.11% CPI adjustment	Amount payable for the dates of service at issue
G0299-TG	$[redacted]/unit	$[redacted]	$[redacted]	[redacted]/unit
G0156-TG	$[redacted]/unit	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is not due additional reimbursement for the dates of service at issue.

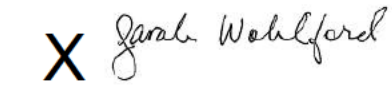
IV. ORDER

The Director upholds the Respondent's determination dated October 13, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X 

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford